MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes ( ) No
Requestor's Name and Address Alta Healthcare Clinic, L.P. 6300 Sammuell Blvd. #112 Dallas, TX 75228	MDR Tracking No.: M4-04-1317-01 TWCC No.: Injured Employee's Name:
Respondent's Name and Address Texas Mutual Insurance Co. Box 54	Date of Injury: Employer's Name: Insurance Carrier's No.: Unknown

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
12/31/02	12/31/02	72100-WP, 97032, 97250, 97265, & 99204-MP	$292.00	

PART III: REQUESTOR'S POSITION SUMMARY

Position Summary dated 09/19/03 states in part, "…No EOB has been received for this service. The carrier responded to the request for reconsideration. The carrier response included payment and EOB's for other dates requested, but did not include an EOB for this date… This is the initial evaluation of [injured worker] for Alta Healthcare, which occurred only 11 days after his reported injury..."

PART IV: RESPONDENT'S POSITION SUMMARY

Position Summary dated 10/16/03 states in part, "…The carrier has no record of receipt showing properly completed bills or a proper request for reconsideration. Consequently, there are no EOBS and the services listed on the table do not qualify for dispute resolution…"

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

- CPT Code 72100-WP for date of service 12/31/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of request for reconsideration. Per the 1996 Medical Fee Guideline, Radiology/Nuclear Medicine Ground Rule (I)(A)(2) reimbursement in the amount of $56.00 (PC$: $22.00 + TC$: $34.00) is recommended.

- CPT Code 97032 (2 units) for date of service 12/31/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of request for reconsideration. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of $44.00 ($22.00 x 2) is recommended.

- CPT Code 97250 for date of service 12/31/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of request for reconsideration. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of $43.00 is recommended.

- CPT Code 97265 for date of service 12/31/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of request for reconsideration. Per the 1996 Medical Fee Guideline, Medicine Ground Rule (I)(A)(10)(a) reimbursement in the amount of $43.00 is recommended.

- CPT Code 99204-MP for date of service 12/31/02. Neither party submitted EOBs. Per Rule 133.307(e)(2)(B) the requestor has submitted convincing evidence of request for reconsideration. Per the 1996 Medical Fee Guideline, Evaluation & Management Ground Rule (VI)(A) and the MFG/Medicine Ground Rule (I)(B)(1)(a) reimbursement in the amount of $106.00 is recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
12/31/2002	72100-WP	$56.00	$56.00				
12/31/2002	97032	$44.00	$44.00				
12/31/2002	97250	$43.00	$43.00				
12/31/2002	97265	$43.00	$43.00				
12/31/2002	99204-MP	$106.00	$106.00				
				Total Left Column:			$292.00
				Total Amount Due:			$292.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of $292.00. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Authorized Signature	Typed Name	Date of Order
	Marguerite Foster	01-28-05

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on _____. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____